STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING _____ B. WING _____	R 06/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE	**31869 CHICAGO TRAIL NEW CARLISLE, IN 46552**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for a PSR (Post Survey Revisit) to the Recertification and State Licensure Survey completed on April 18, 2011 Survey dates: May 31, June 1, and 2, 2011 Facility Number: 000427 Provider Number: 155672 AIM Number: 100275150 Survey Team: Sandra Haws, RN TC Toni Krakowski, RN Vicki Manuwal, RN Bobbi Costigan, RN Census Bed Type: SNF/NF: 83 Residential: 48 Total: 131 Census by Payor Type: Medicare: 16 Medicaid:40 Other: 75 Total: 131 Sample: 12 Hamilton Communities was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey. Quality review completed on June 3, 2011 by Bev Faulkner, RN	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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